Erratum

Erratum to: Improving Treatment Adherence in Schizophrenia

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For Tables 1 and 2, the bulleted interventions should correspond to the beginning sentences noted in the findings sections.

The correct Tables are now presented on the next page.

Table 1. Patient factors that influence treatment adherence

Treatment type	Facilitators to adherence	Findings
Psychiatric medication	<ul style="list-style-type: none"> • Awareness of illness, positive expectations medication will be effective, strong provider-patient relationship. • Desire to live normal life, freedom from psychotic symptoms. • People with first-episode illness: desire for relapse prevention, immediate benefit from medications, family support, alliance with clinician, feeling helps with life goals. 	Promoted adherence.
Outpatient treatment	<ul style="list-style-type: none"> • Participation in Assertive Community Treatment 	Improved odds of filling prescriptions.
Medical medication/treatment	<ul style="list-style-type: none"> • Understanding of health and consequences of deciding to engage in treatment. • Motivation and personal accountability for own health. 	Improved medical treatment adherence.
Health promotion activities/behaviors	<ul style="list-style-type: none"> • Personal attitudes and beliefs about health, prior experience and attitudes toward hospitalization, cultural orientation, ability to negotiate health system, belief treatment too inconvenient/not worth effort. • Adherence to psychiatric medications, sleep, daily routines, use of educational media, support from family/friends, past experiences with mental/medical treatment improved health knowledge. 	<p>Understands the consequences of engagement in health behaviors.</p> <p>Increased participation in healthy lifestyle choices.</p>
Treatment type	Barriers to Adherence	Findings
Psychiatric medication	<ul style="list-style-type: none"> • Cost burden • Positive attitude toward positive symptoms. 	<p>50 % less likely to report full adherence.</p> <p>Reinforced feelings of safety when non-adherent.</p>
Outpatient treatment	<ul style="list-style-type: none"> • Substance abuse, impaired insight, high levels of hostility, denial of need for treatment. • Missing first appointment post-hospitalization. 	Strongly contributed to non-adherence.
Medical medication/treatment	<ul style="list-style-type: none"> • Serious medical co-morbidities. 	Significant risk for re-hospitalization during first week post-discharge.
Health promotion activities/behaviors	<ul style="list-style-type: none"> • Impaired intellectual capacity, cognitive deficits. • Experiencing stigma, isolation/rejection, pain, insomnia, medication side effects, emotional stress, hopelessness, communication difficulties, auditory hallucinations, delusions, poor dietary habits, unhealthy weight, lack of transportation to gym. 	<p>Increased risk for early hospital re-admission.</p> <p>May decline to engage in health promotion activities due to lack of understanding of consequences</p> <p>Decreased likelihood of participation in health promoting behaviors.</p>

Table 2. Summary of interventions that improve adherence

Intervention category	Interventions	Findings
Psychiatric medications	<ul style="list-style-type: none"> • Environmental supports: therapist weekly home visits, pill counters/organizers, calendars, convenient dosing, organization of belongings, electronic medication monitors. 	Medication adherence rates 90–92 % with supports vs. 73 % with treatment as usual.
	<ul style="list-style-type: none"> • Administration of long acting injectable medications. 	Reduces all-cause hospital readmission and emergency room utilization; saves institutions average of \$404 compared to use of oral medication.
	<ul style="list-style-type: none"> • Adherence Therapy and Motivational interviewing: assessment of medication beliefs, attitudes, knowledge and concerns, education about mental illness and treatment, review of benefits and drawbacks of medication; strategies for relapse prevention and stigma reduction. 	Significantly improved medication adherence, positive and negative symptoms, functioning, insight, and reduced hospitalizations compared to treatment as usual on one trial.
	<ul style="list-style-type: none"> • Customized Adherence Enhancement: medication and psychosocial education, medication routines, communication with providers regarding benefits/burdens of medications, adhering to medications when using substances. 	Associated with good adherence to long-acting injectables (76 % at 6-months) and reduction in missed doses from 46 to 10 %.
Outpatient treatment	<ul style="list-style-type: none"> • Medication Management Coordinators. 	Patients attended more medication appointments and at least one with psychiatrist within 30 days vs. usual care group.
	<ul style="list-style-type: none"> • Assertive Community Treatment. 	2.3 % greater medication possession ratios in outpatient settings.
	<ul style="list-style-type: none"> • Peer Support/Navigators. 	Problem-solving groups significantly reduced missed medication dosages.
	<ul style="list-style-type: none"> • Transitional Care. 	Significantly decreased risk for hospital readmission and were 30 % less likely to be readmitted after 1 year vs. usual care.
Health promotion activities	<ul style="list-style-type: none"> • Frequent reminders. 	Prompts from others, pill organizers, daily schedules/routines (exercise, hygiene, diet, spiritual growth), and use of educational media facilitated participation in health promoting behaviors.
	<ul style="list-style-type: none"> • Encouragement/support from family/important others. 	Enhanced likelihood of adherence to health promoting behaviors.